



Section 1 - Employee/Supervisor

Complete Section 1 and send to the Physician. This form is required prior to the return to work for any occupational injury or illness and for any other injury or illness in accordance with Chapters 8 and 25 of WSDOT's HR Manual.

Employee Name		Org. Code (Required)	Position Title
Supervisor Name		Telephone	Office Address
Date of Injury/Illness	Claim Number (if applicable)		
<input type="checkbox"/> Not Work Related			
Employee Performs the Following Job Tasks:			

Section 2 - Physician's Report

Completion of Section 2 of this form will provide the Department of Transportation with information necessary to assist the employee and their Supervisor in making a successful recovery and return to full job duties. Completion of Section 5 will be exclusively used as Confidential Medical Information, and will be detached from the first two pages to be used by the Safety Office. Please return the forms to the office address above.

This certifies that _____ has been under my care since _____

Date of Last Examination	Date of Next Examination	Est. Date of Medical Treatment Completion
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- ☐ The employee **can** work regular duties ☐ The employee **cannot** work regular duties ☐ The employee can work **modified** duty with restrictions listed below

Physician's Assessment of Worker Restrictions Required During Modified Duty

1. In an 8-hour work day, worker can perform the following activities for the indicated **continuous** duration.

Check applicable length of time in hours. * An explanation must be provided for any item checked "Unsure."

	0	1/2	1	2	3	4	5	6	7	8	Unsure*
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explanation: _____

2. In an 8-hour work day, worker can perform the following activities for the indicated **cumulative** duration.

Check applicable length of time in hours. * An explanation must be provided for any item checked "Unsure."

	0	1/2	1	2	3	4	5	6	7	8	Unsure*
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explanation: _____

3. Worker can lift/carry: * An explanation must be provided for any item checked "Unsure."

In terms of an 8-hour work day: **Occasionally = 1% to 33%** **Frequently = 34% to 66%** **Continuously = 67% to 100%**

	Never	Occasionally	Frequently	Continuously	Unsure*
0 - 5 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 - 30 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrestricted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explanation: _____

4. Worker can use hands for repetitive action such as: *** An explanation must be provided for any item checked "Unsure."**

Simple Grasping

Right ☐ Yes ☐ No ☐ Unsure*
Left ☐ Yes ☐ No ☐ Unsure*

Pushing & Pulling

☐ Yes ☐ No ☐ Unsure*
☐ Yes ☐ No ☐ Unsure*

Fine Manipulation

☐ Yes ☐ No ☐ Unsure*
☐ Yes ☐ No ☐ Unsure*

Explanation: _____

5. Worker can use feet for repetitive movements as in operating foot controls: ***An explanation must be provided for any item checked "Unsure."**

Right Foot ☐ Yes ☐ No ☐ Unsure*

Left Foot ☐ Yes ☐ No ☐ Unsure*

Both Feet ☐ Yes ☐ No ☐ Unsure*

Explanation: _____

6. Worker is able to: *** An explanation must be provided for any item checked "Unsure."**

	Never	Occasionally	Frequently	Continuously	Unsure*
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explanation: _____

7. Visual: ☐ No duty requiring depth perception ☐ No duty requiring color perception
☐ No duty requiring good night vision ☐ No duty requiring good visual acuity

Other _____

8. Exposure to Noise: ☐ No duty requiring acute hearing ☐ No exposures at levels requiring hearing protection
☐ No use of earplugs

Other _____

9. No Exposure to: ☐ Noxious vapors or smoke ☐ Poison oak, etc. ☐ Radiation ☐ Pollens ☐ Bee stings
☐ Dust ☐ Chemicals ☐ Cold temperatures ☐ Hot temperatures

Other _____

10. Scheduling Restrictions: ☐ Part time work only ☐ No rotating shifts ☐ No night work ☐ No overtime

If rest periods are required, indicate how often and for how long:

11. Other Restrictions: ☐ No driving ☐ No work around machinery ☐ No operating heavy equipment
☐ No work at heights ☐ No digging ☐ No respirator usage

Other _____

Physician's Printed Name	Physician's Signature	Date
Office Address		Telephone

Section 3 - Supervisor's Return to Work Plan

☐ Can Accommodate Until _____ ☐ Cannot Accommodate Until _____

If unable to accommodate, indicate reason:

Section 4 - Approval Signatures

Employee	Date
Immediate Supervisor	Date
Safety Officer	Date

Section 5 - Physician's CONFIDENTIAL MEDICAL INFORMATION: for Safety Office File

Subjective Findings	
Objective Findings	
Assessment	
Goal Directed, Time Limited Treatment Plan	
<input type="checkbox"/> There are no restrictions due to medication <input type="checkbox"/> Medication causes restrictions: Can drive Automatic <input type="checkbox"/> Yes <input type="checkbox"/> No Can drive Clutch <input type="checkbox"/> Yes <input type="checkbox"/> No Can work at Heights <input type="checkbox"/> Yes <input type="checkbox"/> No Can climb Ladders <input type="checkbox"/> Yes <input type="checkbox"/> No Can climb Stairs <input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Medicines which affect Driving and/or Working at Heights
Other pertinent information regarding this report	

By signing this form, I authorize the release of information relative to this case to my employer.

Employee Signature _____

Date _____